

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001037	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 REX GROSSMAN BLVD BLOOMINGTON, IN 47403
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K010000	<p>A Life Safety Code Recertification survey was conducted by the Indiana State Department of Health in accordance with Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 11/13/14</p> <p>Facility Number: 006102 Provider Number: 15C0001037 AIM Number: 100274500A</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code Recertification survey, Southern Indiana Surgery Center LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors.</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010029	<p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 3 hazardous areas, such as a general storage room, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any patients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/13/14 at 9:45 a.m. with the administrator, the basement general storage room, which measured</p>	K010029	K029 The center's general maintenance company attached a self closing device on the door to the basement general storage room on 12/2/14. After installation, the AD checked the self closing device to ensure the door and device open and close properly to meet life safety code standards. The AD assigned housekeeping to check the device daily to make sure the door is functioning properly and report any malfunctions.	12/02/2014

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K010046	<p>twenty five hundred square feet and stored combustible paper files, wood pallets, plastic tubs and paper nursing supplies, lacked a self closing device on the room door. This was verified by the administrator at the time of observation and acknowledged at the exit conference on 11/13/15 at 12:55 p.m.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 exit discharge paths were provided with double lighting fixtures on emergency powered illumination. LSC 21.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. LSC 7.9.1.1 says the exit discharge shall include only designated stairs, aisles walkways leading to a public way. LSC 7.9.2.1 requires that emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle, and not less than 0.1 foot candles, measured along the path of egress at floor level. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice</p>	K010046	<p>K046 Double lighting fixtures on the emergency power breaker panel were installed on the exterior of the building outside of the pre-op exit and outside of the surgery suite exit by our general maintenance company on 12/4/14. The AD ensured the double lighting fixtures were installed and tested by the maintenance company. The general maintenance company will check, monitor and record monthly that the lights are in working order. The SISC staff will monitor and inform the AD if they are not working.</p>	12/04/2014

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K010114	<p>could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observations with the administrator on 11/13/14 during a tour of the facility from 9:15 a.m. to 12:50 p.m., the light fixtures located on the exterior of the building outside of the pre operation exit and the surgery suite exit were provided with single light fixtures on the emergency power breaker panel. Based on an interview with the administrator on 11/13/14 at 10:45 a.m., the hours of operation are from 6:30 a.m. to 5:00 p.m. and staff usually come into the facility a half hour before and stay a half hour after closing hours, which would leave the exterior of the pre operation exit and surgery suite exit in darkness at the start and end of the daily shift. The lack of double light fixtures outside the pre operation exit and surgery suite exit was verified by the administrator at the time of observations and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1¾ inches or equivalent and are equipped with a</p>			

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K010114	<p>positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 separation door between the ambulatory surgery center and the adjoining doctor office occupancy was provided with a door label to indicate the fire resistance rating of the door. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/13/14 at 9:35 a.m. with the administrator, the basement corridor between the ambulatory surgery center and the adjoining doctor office had a two hour fire wall separation between the two occupancies. Furthermore, the set of doors in the fire wall had the door labels painted. This was verified by the administrator at the time of observation and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p>	K010114	K114 The general maintenance company removed the paint from the door label and the label reads fire rating 1 1/2 hours. This is the separation door between the ambulatory surgery center and the adjoining doctor office. The AD ensured that the paint was removed from the door label, so the fire rating of 1 1/2 hours is properly displayed. The AD will ensure this label is never painted over again.	12/02/2014
K010130	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance</p>	K010130	K130 Simplex Grinnell brought spare sidewall sprinklers to SISC and the AD observed Simplex Grinnell placing them in the spare sprinkler cabinet on the	12/05/2014

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	<p>with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all patients in the facility if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 11/13/14 during an initial tour of the facility from 9:05 a.m. to 9:25 p.m. with the administrator, the front entrance foyer had a sidewall sprinkler providing sprinkler coverage in the entrance foyer. Based on observation of the spare sprinkler cabinet in the basement sprinkler riser room with the administrator, there were no spare sidewall sprinklers in the spare sprinkler cabinet. The lack of spare sidewall sprinklers was verified by the administrator at the time of observation</p>		<p>premises for replacement purposes on 12/5/14. The AD will also be responsible for making sure spare sprinklers are replaced if any of them are ever utilized.</p>				

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K010144	<p>of the spare sprinkler cabinet and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 1. Based on record review, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 40 of 52 weeks over the past year. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires storage batteries, including electrolyte levels, be inspected at intervals of not more than 7 days and shall be maintained in full compliance with the manufacturer's specifications. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the</p>	K010144	<p>K144 12/10/14 As of 11/21/14 the general maintenance company is conducting and recording a written record of weekly inspections of the starting batteries for the generator. The AD will ensure the generator load test is conducted and recorded monthly by Cummins. The AD will keep and monitor all records of weekly and monthly generator inspections and testing performed by Cummins and the general maintenance company. K144 On 12/2/14 the AD received a letter from Vectren that stated the fuel source for the generator was from a reliable source with a low probability of an interruption of the fuel supply. The AD placed the letter in the generator file. K144 A light lasting 11/2 hours in duration that is emergency hard wired to a battery pack and shines onto the generator was installed on 12/10/14 by our general maintenance company. Our general maintenance company tested the light after installation and will test this light monthly</p>	12/10/2014

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	<p>authority having jurisdiction. This deficient practice could affect all patients and staff.</p> <p>Findings include:</p> <p>Based on review of the Monthly Load Test log with the administrator on 11/13/14 at 9:35 a.m., monthly load tests was the only documentation regarding generator inspections available for review and the administrator indicated there were no weekly inspections conducted. The lack of weekly inspections for the emergency generator was verified by the administrator at the time of record review and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p> <p>2. Based on interview, the facility failed to ensure the off site fuel source for the emergency generator was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas 		and perform a 90 minute test annually. The AD will keep records of the testing.				

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	<p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on and interview with the administrator on 11/13/14 at 9:50 a.m. during record review, the fuel source for the emergency generator was natural gas. Furthermore, the administrator indicated there was no letter from the natural gas provider stating that the fuel source for the generator was from a reliable source with a low probability of an interruption of the fuel supply. This was verified by the administrator at the time of interview and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p> <p>3. Based on observation, the facility failed to provide adequate emergency task lighting in and around 1 of 1</p>			

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	<p>emergency generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires that emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 11/13/14 at 10:40 a.m., the emergency generator, which was located outside and to the south of the basement south exit, was located in a grass covered yard and lacked battery backup lighting. This was verified by the administrator at the time of observation and acknowledged at the exit conference on 11/13/14 at 12:55 p.m.</p>			